



THE FUTURE OF ELDERLY WAIVER

MINNESOTA DEPARTMENT OF HUMAN SERVICES

JULY, 2018

REVISED FEBRUARY, 2019

Executive Summary

Minnesota's Elderly Waiver (EW) program was developed in the 1980s as an alternative to nursing home services. The program serves people age 65 and older who are financially eligible for Medical Assistance, who need the level of care provided in a nursing home, but who choose to receive services in the community. In fiscal year 2017, the program served 29,329 older adults, at a cost of \$343 million dollars (state and federal funds).

EW participants are able to choose the services that best meet their needs from the EW service menu. The service menu includes a wide range of offerings, including in-home services such as homemaker and home-delivered meals, group day services such as adult day service, and residential services such as customized living (a service frequently delivered in assisted living settings). In 2017, roughly 42 percent of EW participants received customized living services, and customized living represented 62 percent of overall EW program spending. EW participants who receive customized living are generally older than participants who receive other waiver services, and are more likely to need behavioral support.

Participants report high levels of satisfaction with the EW program. The majority report that their services meet their needs and goals, that they would recommend the people who are paid to help them, that their paid support staff treat them with respect, and that they know who to call if their needs change or if they have a complaint.

Minnesota has put a number of strategies in place to meet the needs of older adults through the EW program, while managing growth in the program. An important strategy has been reaching people early, before they even become eligible for EW, in order to prevent or delay their spenddown to MA, and prevent or delay the use of more expensive services such as nursing home or assisted living services. These strategies include upstream programs such as Alternative Care (AC) and Essential Community Supports (ECS); the Return to Community Initiative to assist private paying nursing home residents to return to the community early in their stays; and Long Term Care Options Counseling to ensure people have information about a full range of options before making a decision to move to assisted living. Supporting family caregivers is another important strategy. The EW program is designed to support the continuation of informal caregiving, by supplementing what family caregivers can provide, and by providing services specifically aimed at providing respite and other types of support to caregivers.

The EW program has a number of specific design features that are intended to manage growth and spending. EW services and budgets are tailored to individual needs. The state has taken significant steps to manage costs, ensure consistency, and enforce policies for the customized living service. And finally, the state implemented changes to the nursing facility level of care (NF LOC), which governs eligibility for HCBS programs including EW.

Despite the significant progress Minnesota has made to effectively serve older adults in their homes and communities, Minnesota faces challenges in maintaining and continuing that momentum. These challenges include lack of availability of in-home services; workforce shortages that impact all service delivery models; continued growth in the assisted living market, which drives increased use of this service within EW; and the increasing complexity of needs of EW participants.

Minnesota has a history of successes upon which to build. Minnesota's publicly-funded long-term services and supports for older adults can not only be maintained but strengthened, in order to serve

older adults now and into the future. Minnesota can do this by: ensuring that considerations of equity are embedded in all decisions related to the EW program; addressing service rates, in order to ensure that services are available for public program participants into the future; developing and promoting cost-effective services, including Consumer Directed Community Supports (CDCS) options; evaluating incentives for the Alternative Care (AC) program and potential cost savings to the state; understanding the spenddown trajectory for people prior to becoming eligible for EW in order to develop data-driven strategies to prevent or delay spending down; and paying for quality in assisted living.

The state is faced with demographic realities and must respond. The state can build on a strong foundation to ensure this program continues to meet the needs of older adults for many years to come.

Elderly Waiver Background

Minnesota has a long history of innovation in serving older adults. In 1982, Minnesota created the state's first Medicaid waiver, called the Elderly Waiver. Prior to this time, Medicaid was only available to pay for long-term services and supports (LTSS) provided in nursing homes. Under a plan approved through a federal authority, called a 1915(c) waiver, the state was able for the first time to use Medicaid to pay for LTSS provided in the community. Like all Medicaid-covered services, Elderly Waiver services are paid through a combination of federal and state dollars.

Minnesota's Elderly Waiver (EW) has been in continuous operation since 1982. The waiver serves people age 65 and older who are financially eligible for Medical Assistance (Minnesota's name for its Medicaid program), who need the level of care provided in a nursing home, but who choose to receive services in the community. Services provided in the community are known as home and community-based services (HCBS). Most of us, as we get older, prefer to remain in our own home for as long as possible. The EW program supports that goal for individual participants. It's also more cost-effective for individuals and for the state to serve people in their homes and communities, rather than in an institution. The program has been a critical component of the state's efforts to "balance" its LTSS system, in order to rely less on nursing facility services, support more individuals in the community, and ensure that older adults have meaningful choice about where to live and receive services.¹

Minnesota has chosen to include a broad range of services in its EW service menu. EW participants are able to choose services from this service menu to meet their particular needs, goals, and preferences. The EW service menu includes such services as:

- Adult day services
- Case management
- Chore services
- Companion services
- Family caregiver support services, including respite
- Home health aides
- Home-delivered meals
- Homemaker services

¹ https://mn.gov/dhs/assets/Balancing-LTSS-status-check_tcm1053-305462.pdf

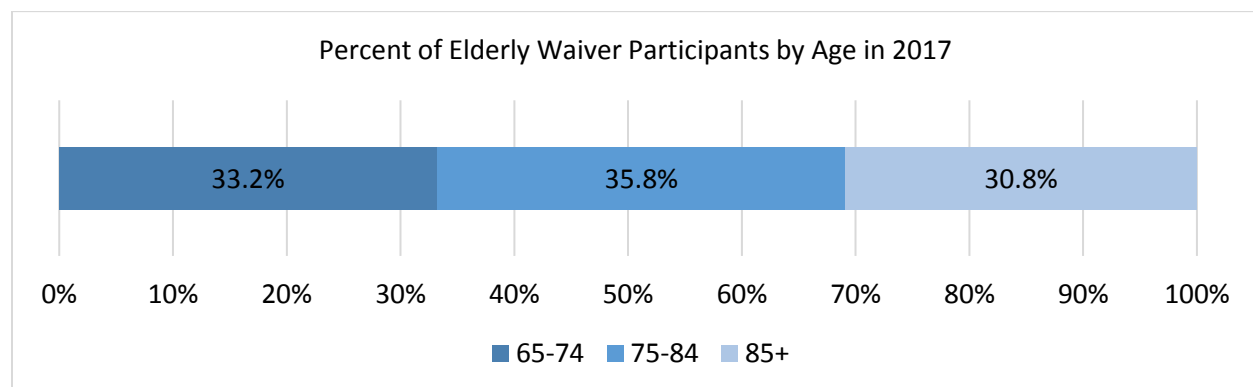
- Home and vehicle modifications
- Individual community living support
- Non-medical transportation
- Personal emergency response systems
- Personal care assistance
- Residential services, such as assisted living or foster care
- Skilled nurse visits
- Specialized equipment and supplies

EW participants also have the option to hire their own workers and direct their own services, through the Consumer Directed Community Support (CDCS) option.

Who Are We Serving?

Demographics

The age of Elderly Waiver program participants is distributed quite evenly, with roughly a third age 65 to 74, 75 to 84, and 85 and older (see the graph below). Nearly three quarters of EW participants in 2017 were female (72%).



Source: DHS Data Warehouse, State Fiscal Year 2017

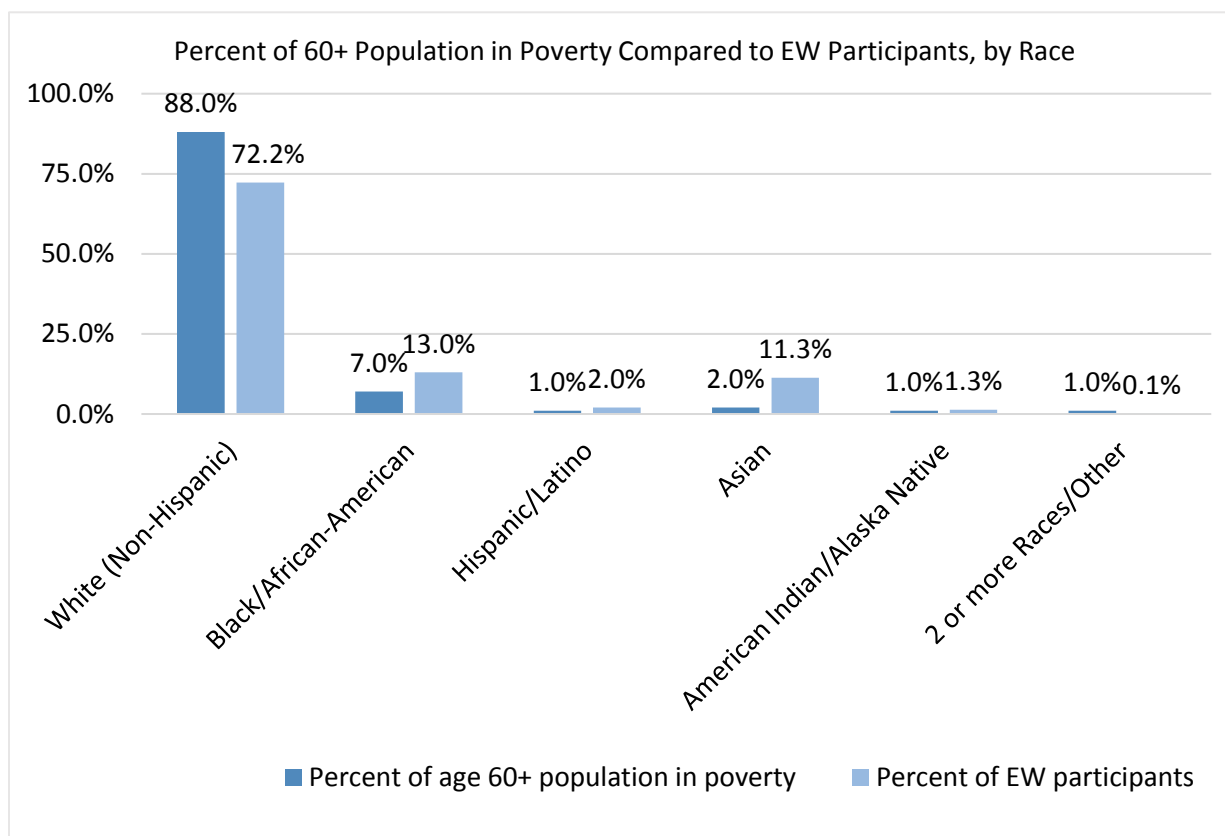
While the majority of EW participants are white, a growing number of participants are people of color. The number of Asian, Black, and Latino participants grew between 20 and 37 percent between 2013 and 2017 (see the table below).

Race / Ethnicity	2013 EW	2017 EW	% Change 2013-2017
Asian or Pacific Islander/Native Hawaii	10.2%	11.5%	19.6%
Black or African American	10.6%	13.7%	37.3%
American Indian/Alaskan Native	1.4%	1.4%	3.1%
White	74.3%	68.9%	-1.7%
Hispanic or Latino	1.7%	2.1%	30.3%

Race / Ethnicity	2013 EW	2017 EW	% Change 2013-2017
Other or Unable to determine	1.7%	2.4%	48.1%
	100.0%	100.0%	

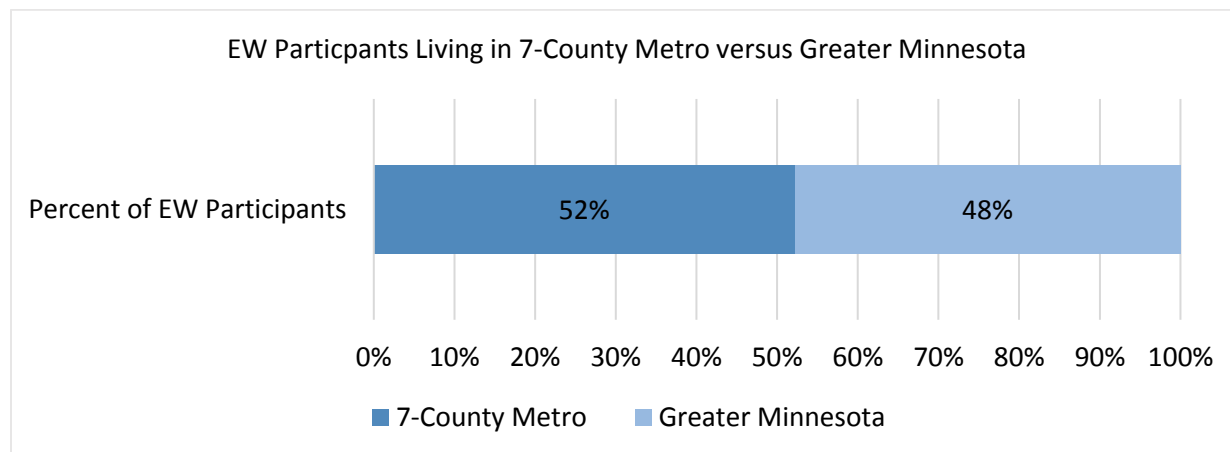
Source: DHS Data Warehouse, State Fiscal Years 2013 and 2017

The graph below compares the race and ethnicity of EW participants with people in the general population age 60 and older who are in poverty. According to this comparison, the EW program serves a slightly smaller proportion of white people and a slightly larger proportion of black/African Americans and Asian/Asian Americans.



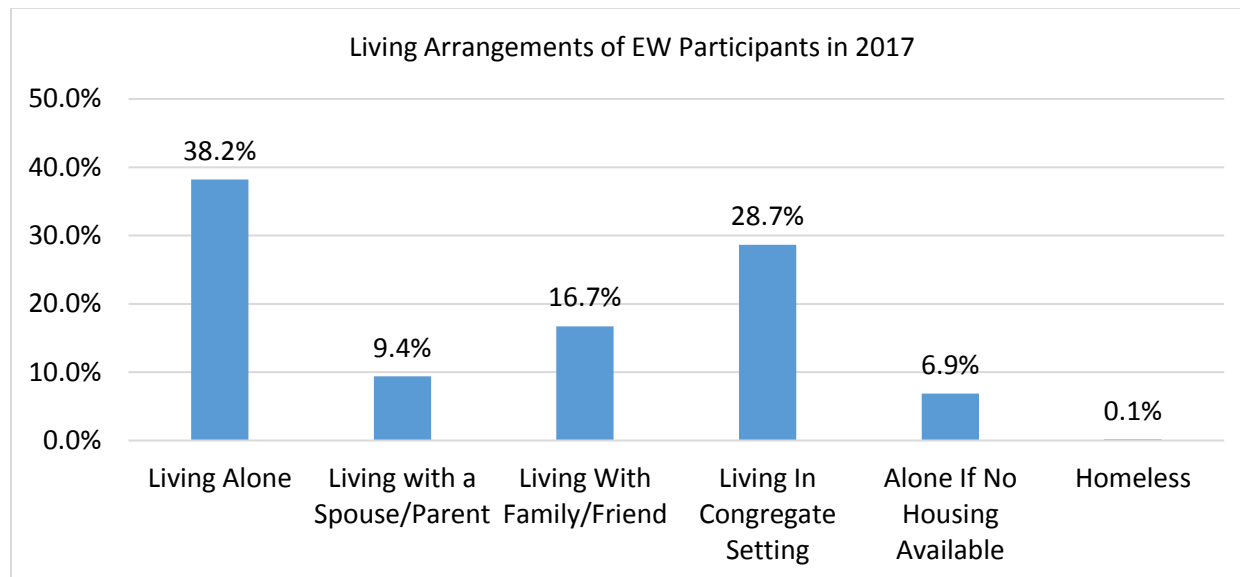
Source: DHS Data Warehouse, State Fiscal Years 2015; Integrated Public Use Microdata Series data, 2014

A small majority of EW participants live in the 7-county Twin Cities metropolitan area (52%).



Source: DHS Data Warehouse, State Fiscal Years 2013-2017

In 2017, more than a third of EW participants were living alone (38%), and another 7 percent would have likely been living alone, or even homeless, without the housing planned for in their long term care services assessment. Fifty five percent of participants were living with a spouse, other family or friends, or in a congregate setting. Less than one percent of EW participants were homeless at the time of their last assessment.



Source: DHS Data Warehouse, State Fiscal Years 2013-2017

Level of Need in the EW Program Population

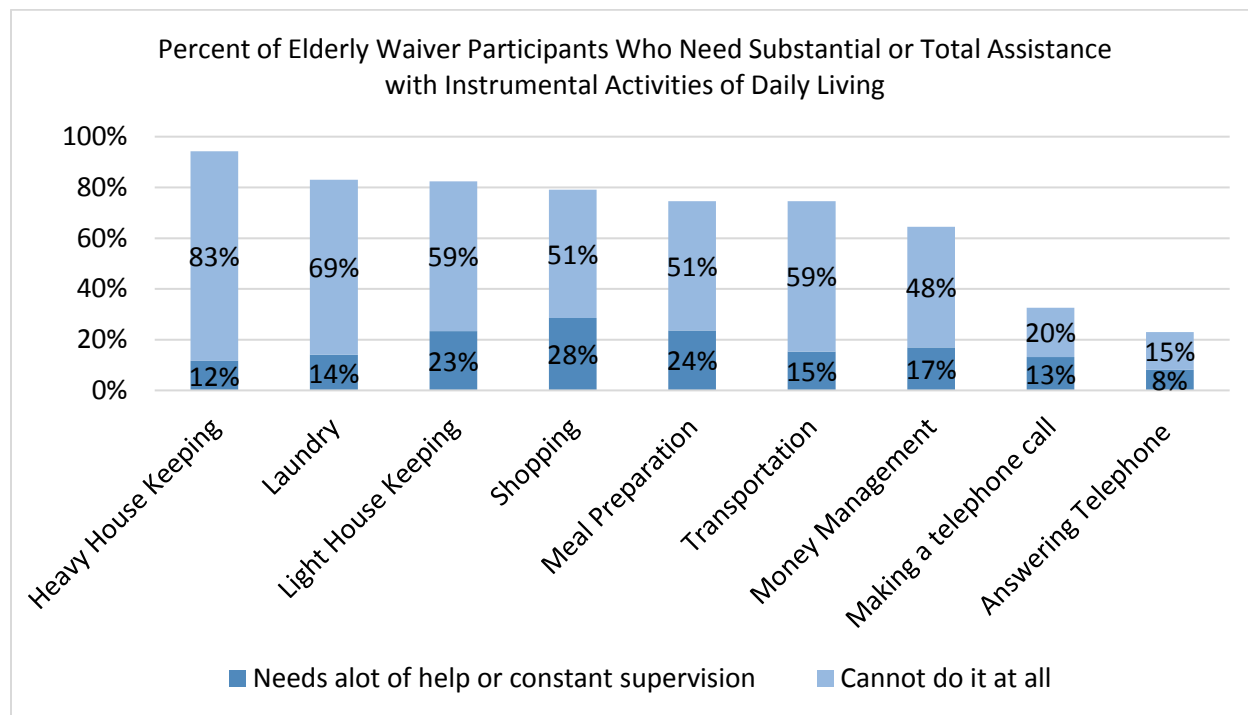
Minnesota has a 12-level Case Mix Classification system to describe the level of care needs each individual has at the time of their assessment. Case Mix L is the lowest level of care needs, and Case Mix K is the highest level. In 2017, the most common Case Mix levels were L, B, E, and D.

Case Mix	Case Mix Description	2013	% Case Mix in 2013	2017	% Case Mix in 2017
L	Very Low ADL	6,486	23%	7,366	24%
A	Low ADL	4,851	17%	2,630	9%
B	Low ADL + Behavior	4,671	16%	5,772	19%
C	Low ADL + Special Nursing	230	1%	243	1%
D	Medium ADL	3,547	12%	4,094	13%
E	Medium ADL + Behavior	3,716	13%	4,151	14%
F	Medium ADL + Special Nursing	213	1%	259	1%
G	High ADL	1,097	4%	1,513	5%
H	High ADL + Behavior	1,533	5%	1,852	6%
I	Very High ADL + Feeding	899	3%	1,130	4%
J	High ADL + Severe Neurological Impairment/Behavior	1,012	4%	1,026	3%
K	High ADL + Special Nursing	511	2%	470	2%
		28,766	100%	30,506	100%

Source: DHS Data Warehouse, State Fiscal Years 2013-2017

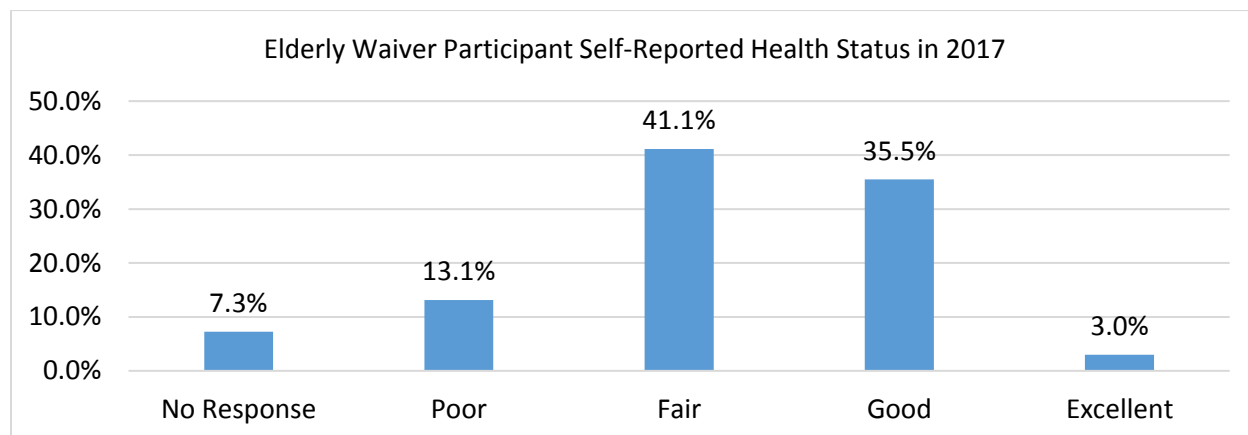
Whereas Case Mix classifications are largely determined by Activities of Daily Living, activities related to caring for oneself, Instrumental Activities of Daily Living (or IADLs) are more about taking care of personal business. A person's ability to perform ADLs and IADLs, or to access needed support, helps them remain as independent as possible as they age.

The graph below shows the IADLs that EW participants needed substantial or total assistance with in 2017, in rank order.



Source: DHS Data Warehouse, State Fiscal Years 2013-2017

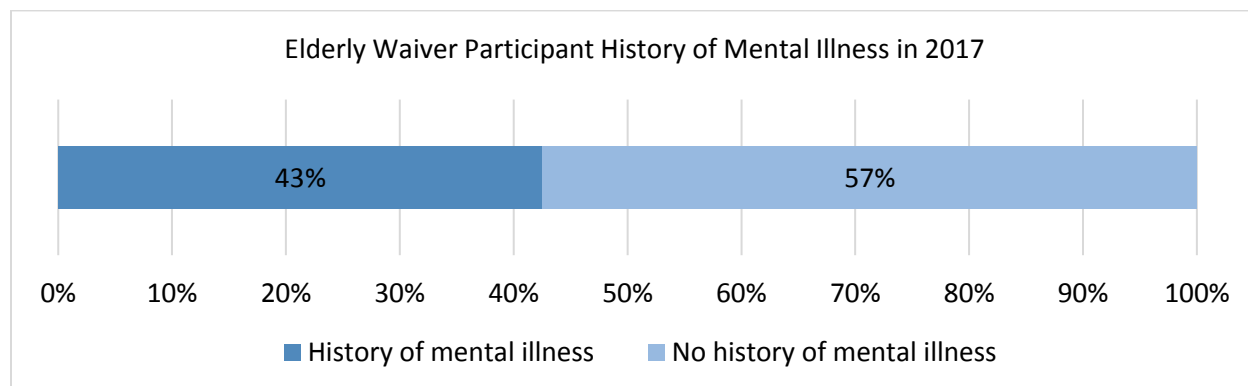
The next few figures have to do with the health of EW participants. First, in terms of overall health, more than a third of EW participants reported that they are in fair health (41%). Nearly the same proportion of participants described their health as good or excellent (39%). Thirteen percent described their overall health as poor, and 7 percent did not respond.



Source: DHS Data Warehouse, State Fiscal Years 2013-2017

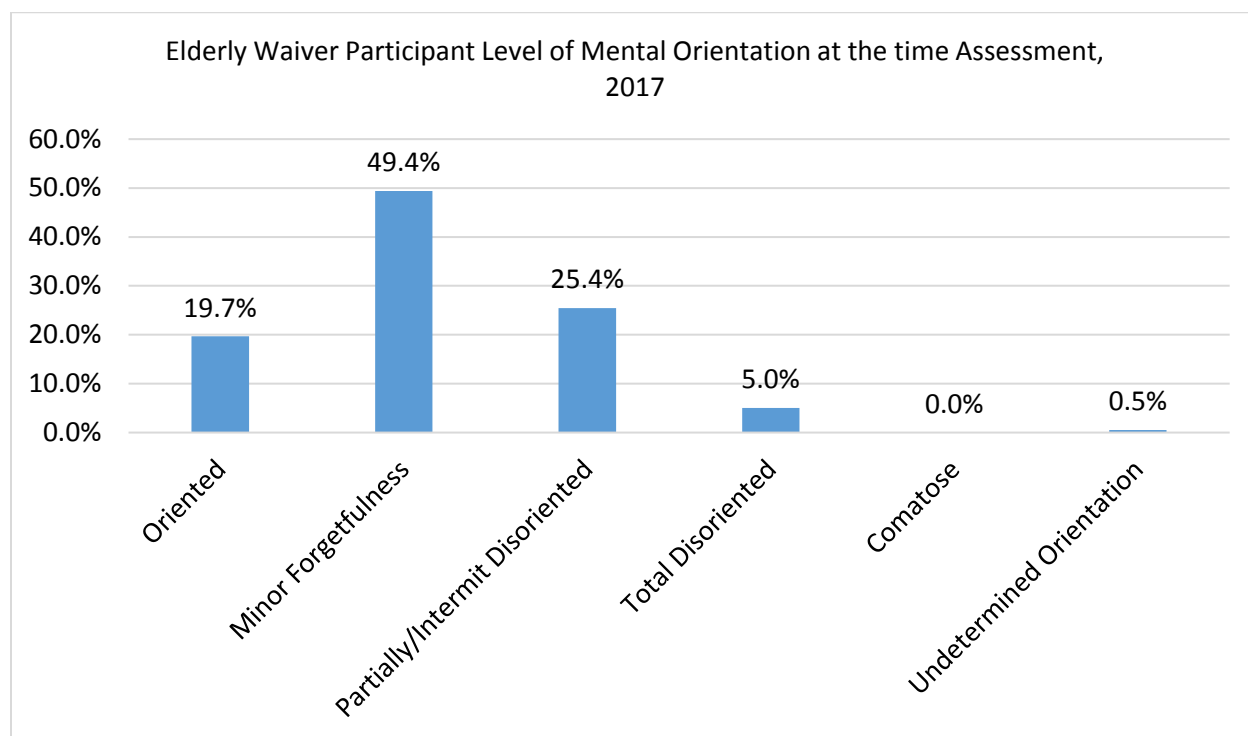
In long-term care consultation (LTCC) assessments, which are used to determine program eligibility, participants are asked if they have a diagnosis of a mental illness from a qualified professional. In 2017,

well more than a third of EW participants reported having a have a mental illness (43%).



Source: DHS Data Warehouse, State Fiscal Years 2013-2017

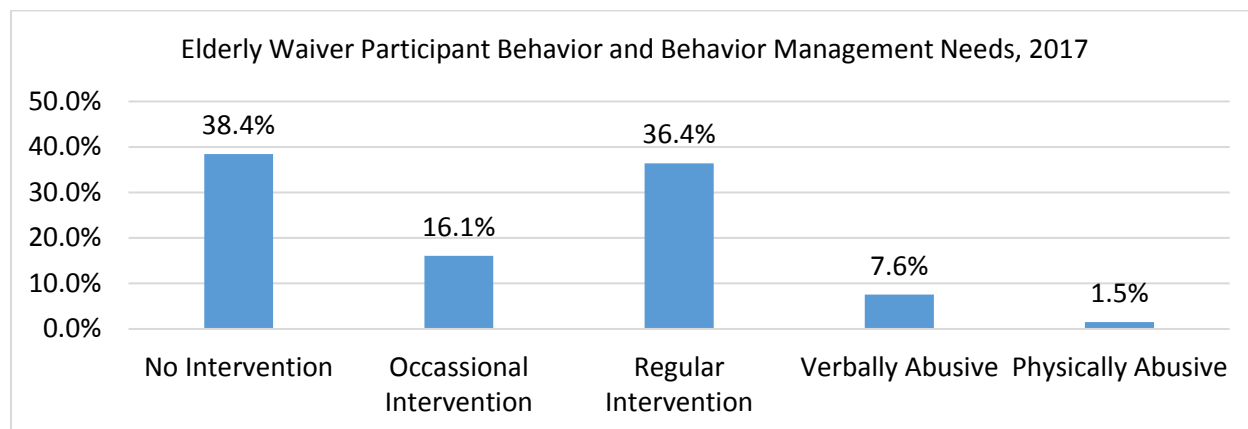
In terms of mental orientation, more than two thirds (69%) of EW participants were assessed to be fully oriented or have minor forgetfulness. The remaining 31 percent show noticeable disorientation.



Source: DHS Data Warehouse, State Fiscal Years 2017

In terms of behavioral needs, the majority of EW participants require little or no support (55%), with 38 percent requiring no support at all. However, more than a third require regular support with behavioral

concerns (36%), and 9 percent of participants are either verbally or physically abusive.



Source: DHS Data Warehouse, State Fiscal Years 2013-2017

Who Are We Serving through Customized Living?

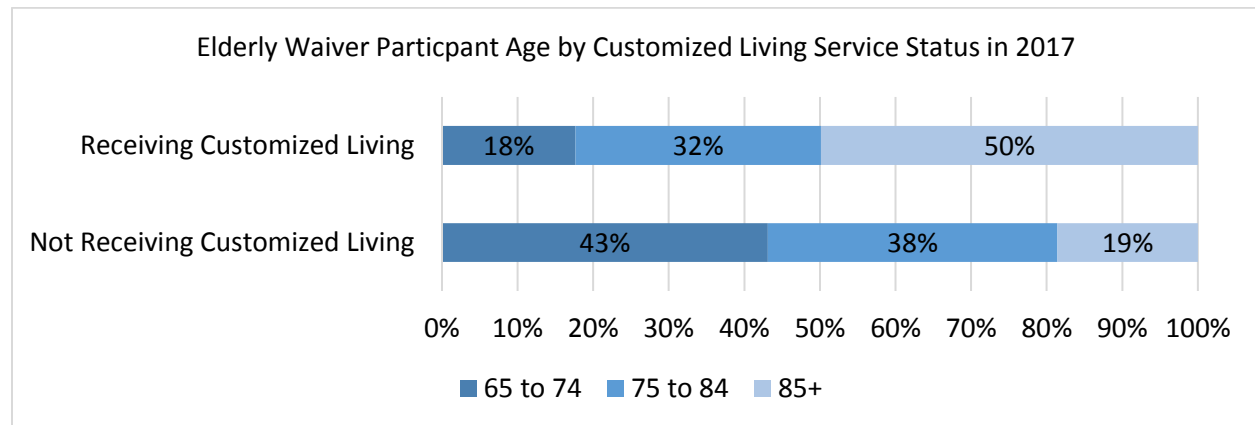
Customized living is one of the services available to EW participants. Customized living is a package of regularly scheduled health-related and supportive services provided to a person who lives in a registered housing with services establishment². Many of these settings meet the definition of assisted living³.

In 2017, roughly 42 percent of EW participants received customized living services, and customized living represented approximately 62 percent of overall EW program spending. More information about the use of customized living is provided in the “Trends in Service Utilization and Spending” section of this report.

EW participants who received customized living were generally older than participants who received other waiver services. In 2017, a full 50 percent of customized living recipients were 85 or older, whereas just 19 percent of recipients of other waiver services were 85 or older.

² “Housing with services establishment” is defined in [Minnesota Statute, Chapter 144D](#)

³ “Assisted living” is defined in [Minnesota Statute, Chapter 144G](#)



Source: DHS Data Warehouse, State Fiscal Years 2013-2017

The Case Mix Classifications vary substantially among EW participants who do and do not receive customized living services. Perhaps the most striking difference is that participants receiving customized living are more likely to need behavioral support (see Case Mix B, E, H, and J below). Special nursing needs are also more common among customized living recipients.

Case Mix	Case Mix Description	Not Receiving Customized Living	Receiving Customized Living
L	Very Low ADL	33.6%	8.5%
A	Low ADL	10.6%	5.6%
B	Low ADL + Behavior	13.7%	26.4%
C	Low ADL + Special Nursing	0.4%	1.4%
D	Medium ADL	16.6%	9.0%
E	Medium ADL + Behavior	7.6%	22.9%
F	Medium ADL + Special Nursing	0.3%	1.6%
G	High ADL	6.2%	3.4%
H	High ADL + Behavior	4.0%	9.4%
I	Very High ADL + Feeding	3.6%	4.1%
J	High ADL + Severe Neurological Impairment/Behavior	2.2%	5.2%
K	High ADL + Special Nursing	1.0%	2.4%
		100.0%	100.0%

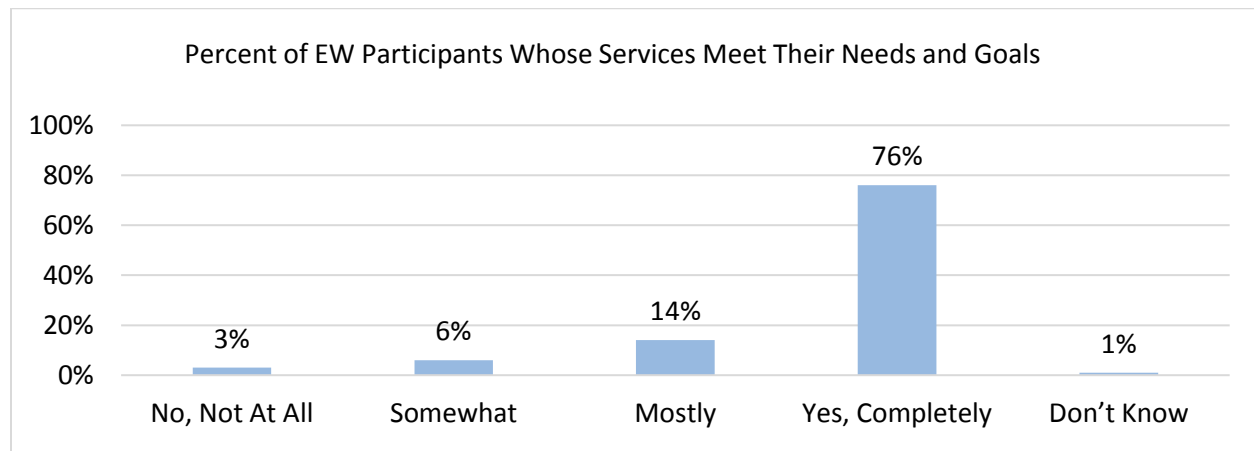
Source: DHS Data Warehouse, State Fiscal Years 2013-2017

What Are Participants Telling Us?

In the past several years, DHS has been participating in the National Core Indicators Aging and Disabilities Adult Consumer Survey (NCI-AD). The NCI-AD is one way that DHS measures quality and uses

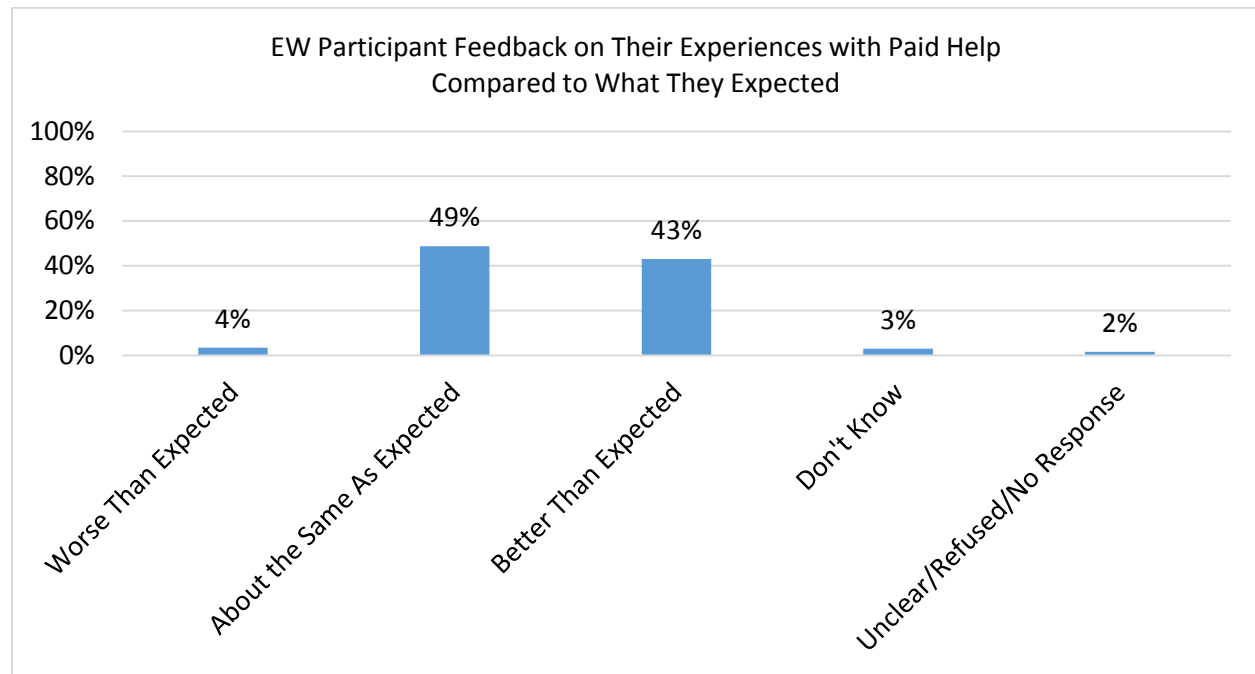
the results to improve services and supports. The NCI-AD survey was developed by the National Association of States United for Aging and Disabilities (NASUAD) and the Human Services Research Institute (HSRI) as a validated tool to assess states' publicly funded Long Term Services and Supports. The NCI-AD is how DHS hears directly from people about how well their services and supports help them to live, work, and engage in their community.

According to the 2015-2016 NCI-AD survey results, three quarters of EW participants reported that the services they receive through the program allow them to completely meet their goals. Another 20 percent of respondents said that the services helped them mostly or somewhat meet their goals. Just 3 percent reported that the services are not helping them meet their goals.



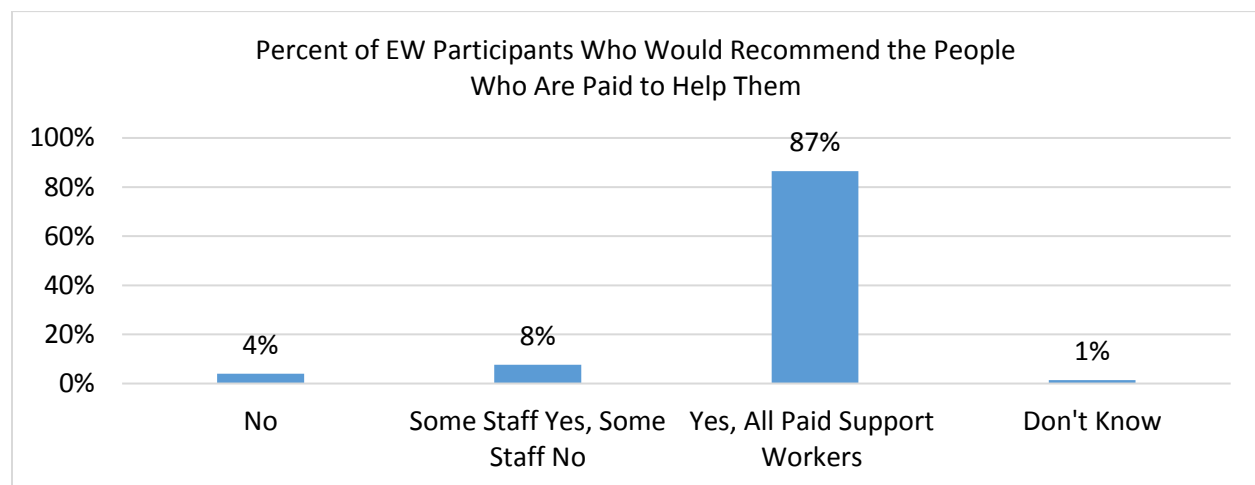
Source: National Core Indicators Aging and Disability Adult Consumer Survey, 2015-2016

EW participants also report favorable experiences with their paid care providers. Well more than a third (43%) of respondents reported that their paid care providers exceeded their expectations. Another 49 percent reported that their expectations are being met, with only 4 percent of respondents saying that their experience is worse than they expected.



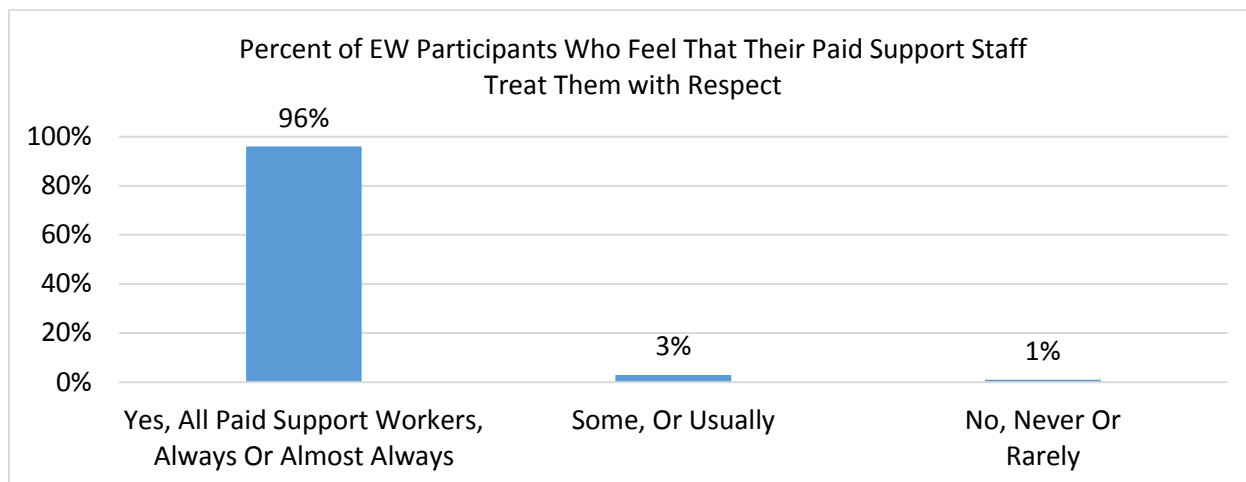
Source: National Core Indicators Aging and Disability Adult Consumer Survey, 2015-2016

The vast majority of EW participants would recommend their paid care providers to others (87%). Only 4 percent reported that they would not recommend their paid care givers to someone else.



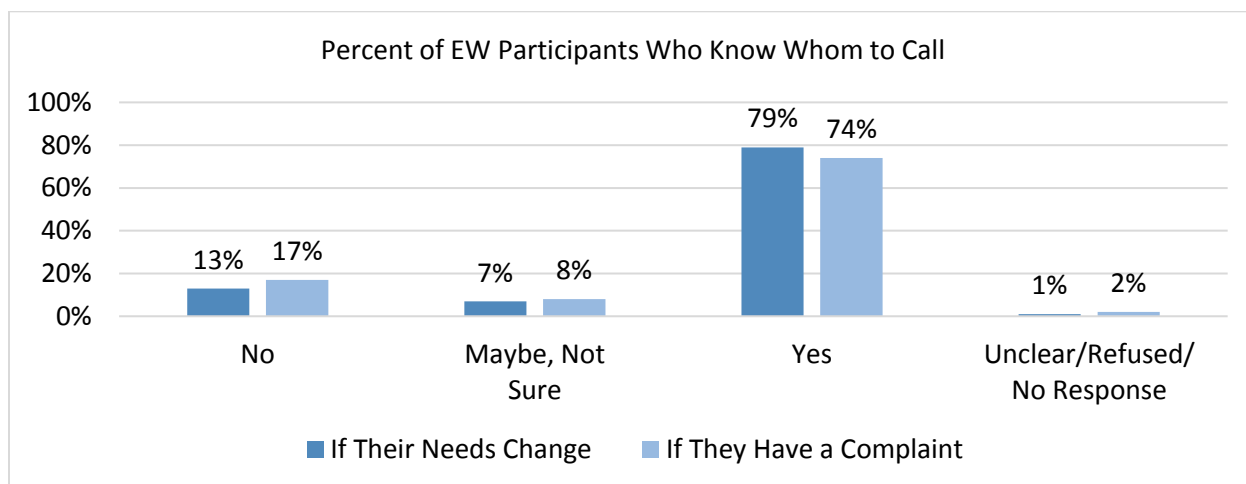
Source: National Core Indicators Aging and Disability Adult Consumer Survey, 2015-2016

Ninety-six percent of respondents reported that their paid care providers treat them with respect. Only 1% said that they are not treated with respect by their care staff.



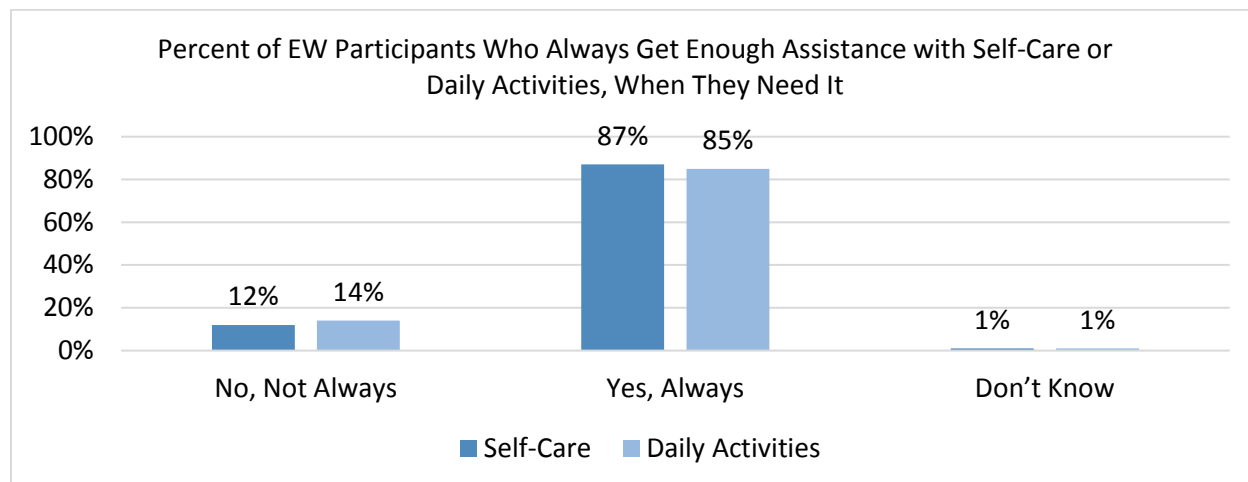
Source: National Core Indicators Aging and Disability Adult Consumer Survey, 2015-2016

A strong majority of EW participants know who to call if something is not right about their care, or something needs to change (74 to 79%). However, 13 to 17 percent did not know who to contact, and additional respondents were unsure.



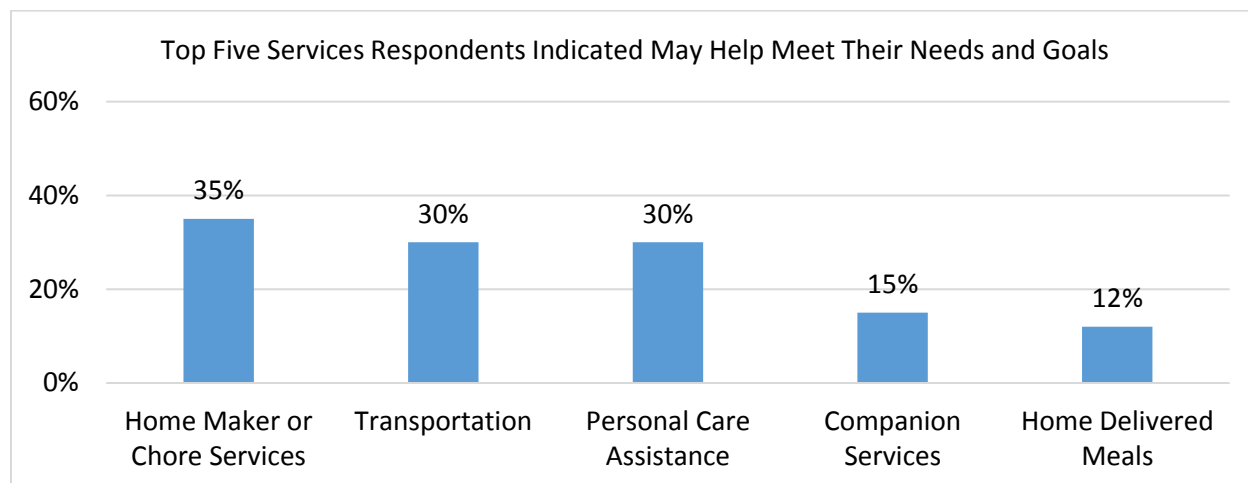
Source: National Core Indicators Aging and Disability Adult Consumer Survey, 2015-2016

The vast majority of EW participants are receiving the help they need with personal care and other daily activities (85 to 87%). However, about 1 out of 7 respondents reported that sometimes they could use more assistance than they currently receive.



Source: National Core Indicators Aging and Disability Adult Consumer Survey, 2015-2016

In the NCI-AD survey, EW participants were asked what additional services might help them meet their goals, if their goals were not yet fully met. More than a third of respondents (35%) indicated that chore or homemaker services would be useful. Transportation and additional personal care assistance were named next, followed by companion and home delivered meal services.



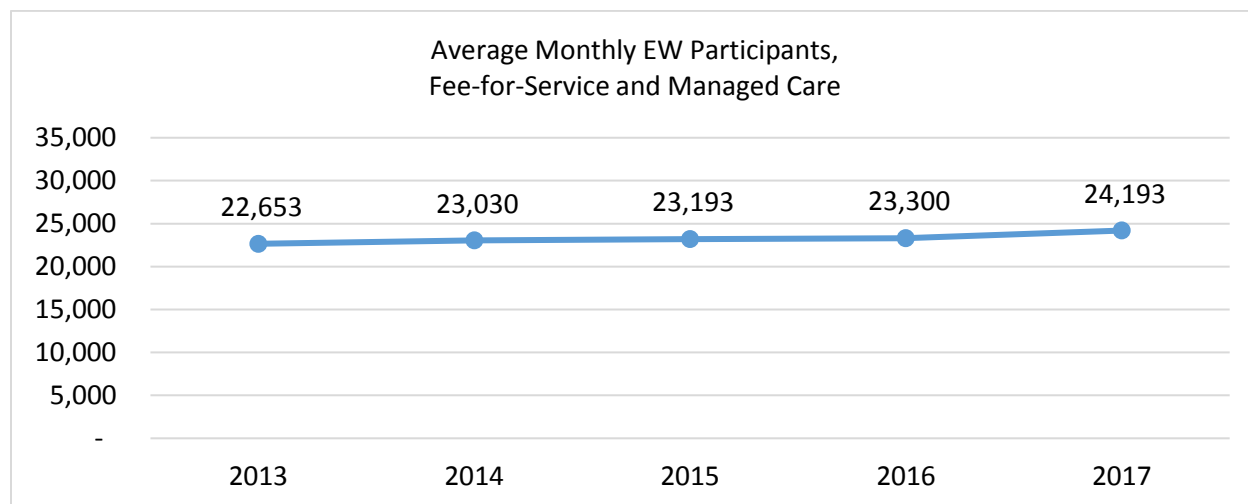
Source: National Core Indicators Aging and Disability Adult Consumer Survey, 2015-2016

Trends in Service Utilization and Spending

Elderly Waiver participants are served through two purchasing models: through a fee-for-service arrangement, or through a capitation arrangement coordinated by health plans. The vast majority of EW participants receive services coordinated by health plans. In 2017, 92 percent of EW participants were served in the Managed Care environment.

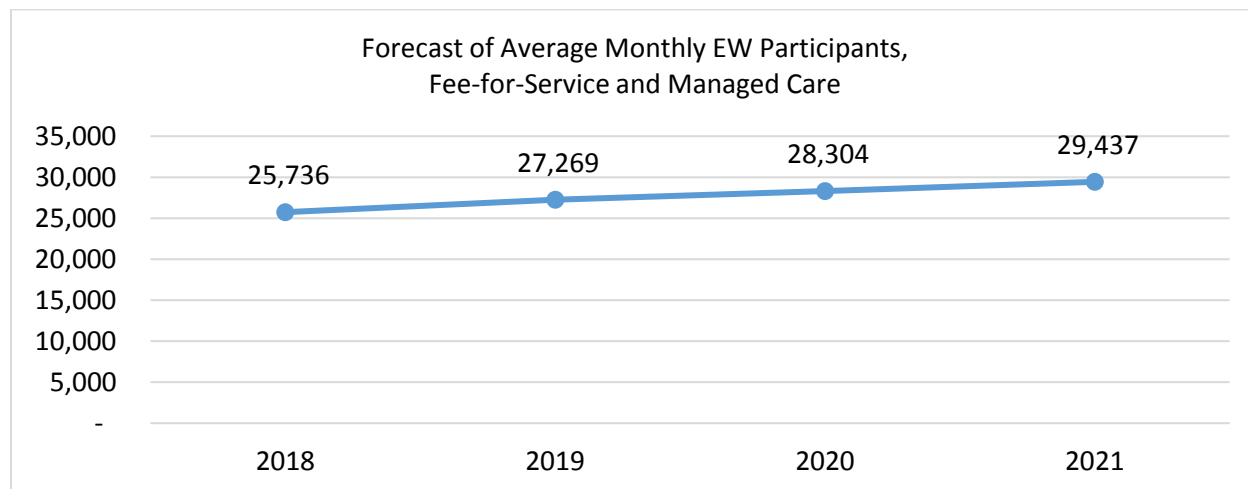
Under the managed care purchase model, a health plan receives a per-member per-month capitation payment and arranges and pays for EW services for all EW enrollees in the health plan. Under the fee-for-service purchase model, counties and tribes arrange for and authorize payments for EW services through the state's Medicaid Management Information System (MMIS). The graphs in this section combine these types of EW payments.

In the past five years, the number of older Minnesotans served through EW has grown year by year. In 2017, over 24,000 people participated in the program in a given month; this is an increase of 7 percent over the number of people served per month in 2013. The graph below shows program participant numbers for the past five fiscal years.



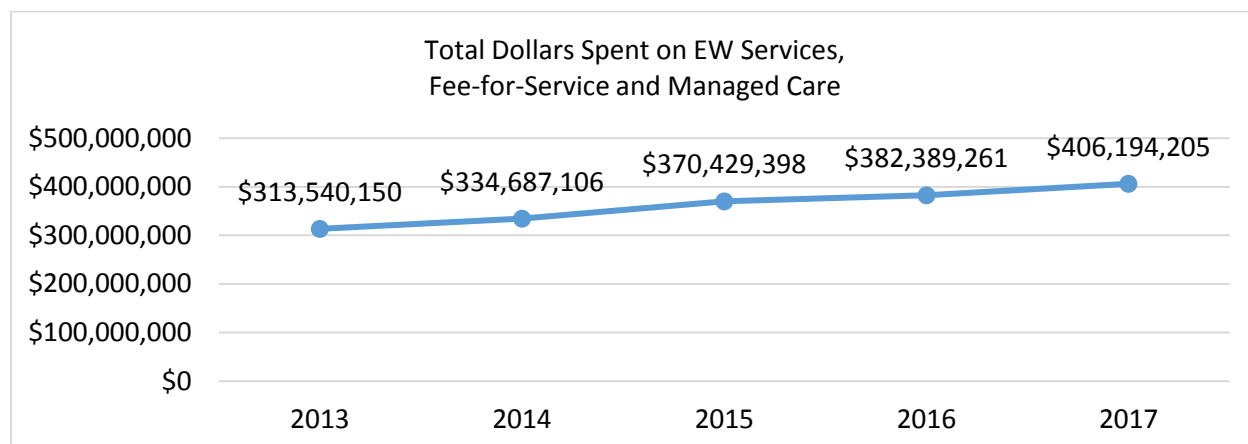
Source: Elderly Waiver Program Forecast, February 2018. Graph revised February 2019.

Looking forward, participation in the EW program is expected to grow. The graph below shows the projected average monthly participant counts through 2021.



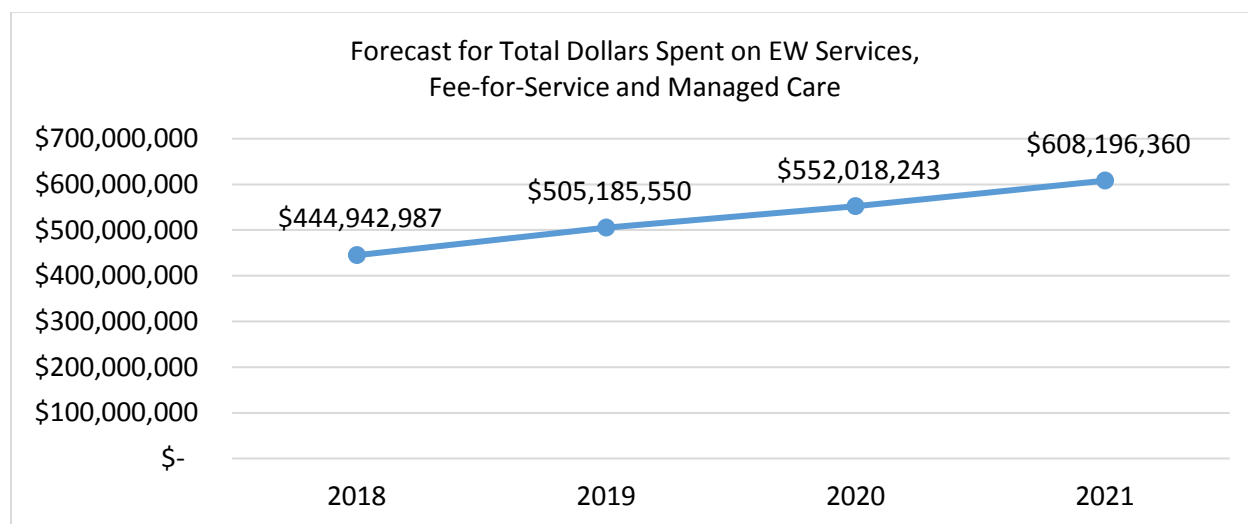
Source: Elderly Waiver Program Forecast, February 2018

In the past five years, overall program spending has increased. In 2017, Minnesota spent over \$400 million on EW services. Between 2013 and 2017, overall program spending has increased 7 percent per year, on average. The graph below reports the number of dollars spent on EW services in the past five years.



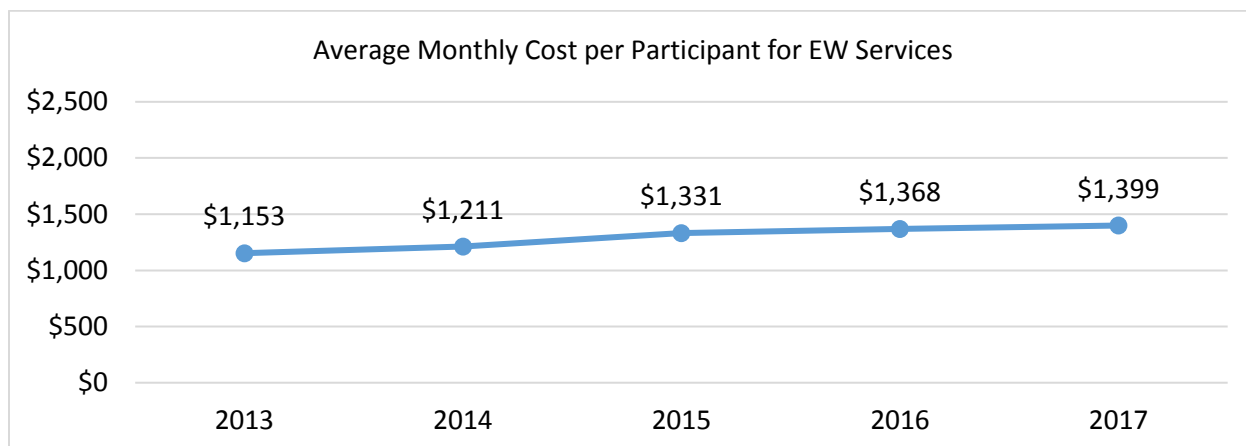
Source: Elderly Waiver Program Forecast, February 2018. Graph revised February 2019.

Between now and 2021, total spending for the EW program is expected to increase year by year, growing at an average rate of 10 percent per year.



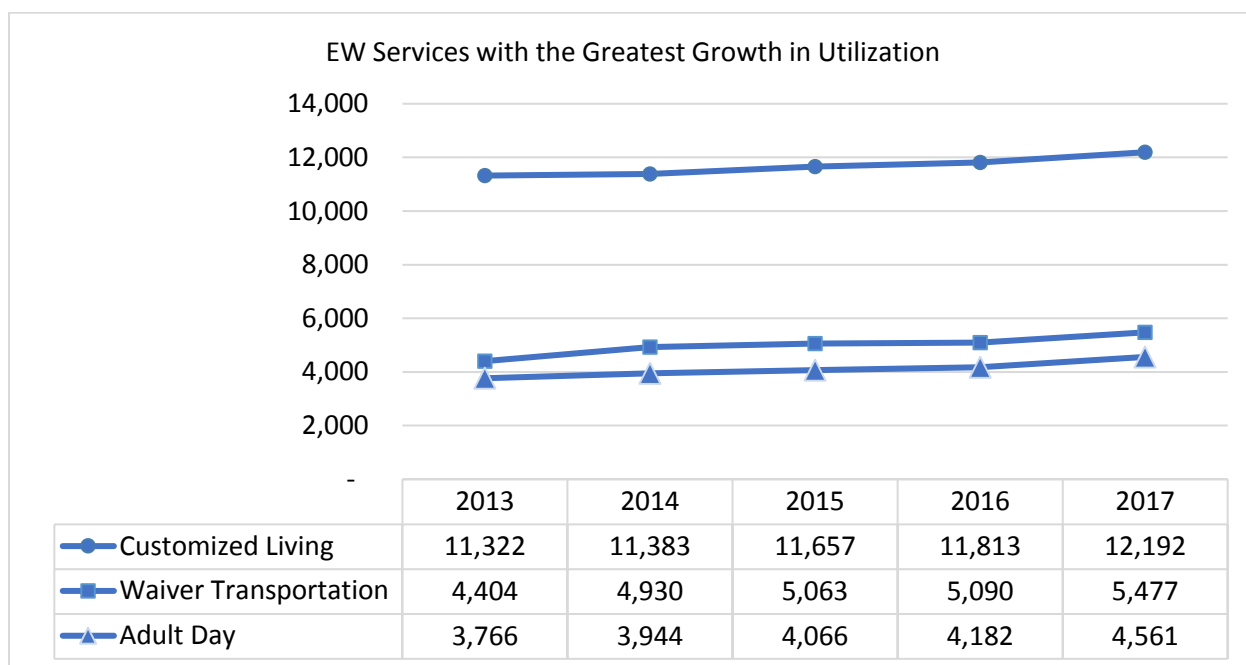
Source: Elderly Waiver Program Forecast, February 2018

Overall program spending is increasing because of increased enrollment, but also because the average spending per participant is increasing. In 2017, the average monthly cost per EW participant was \$1,399. Between 2013 and 2017, the cost per participant increased by 21 percent, or 5 percent per year, on average.



Source: Elderly Waiver Program Forecast, February 2018. Graph revised February 2019.

Participation and spending are growing in some EW services more than others. The three services with the greatest growth in participation are customized living, waiver transportation, and adult day services. The graph below shows the rising participant numbers for these services.

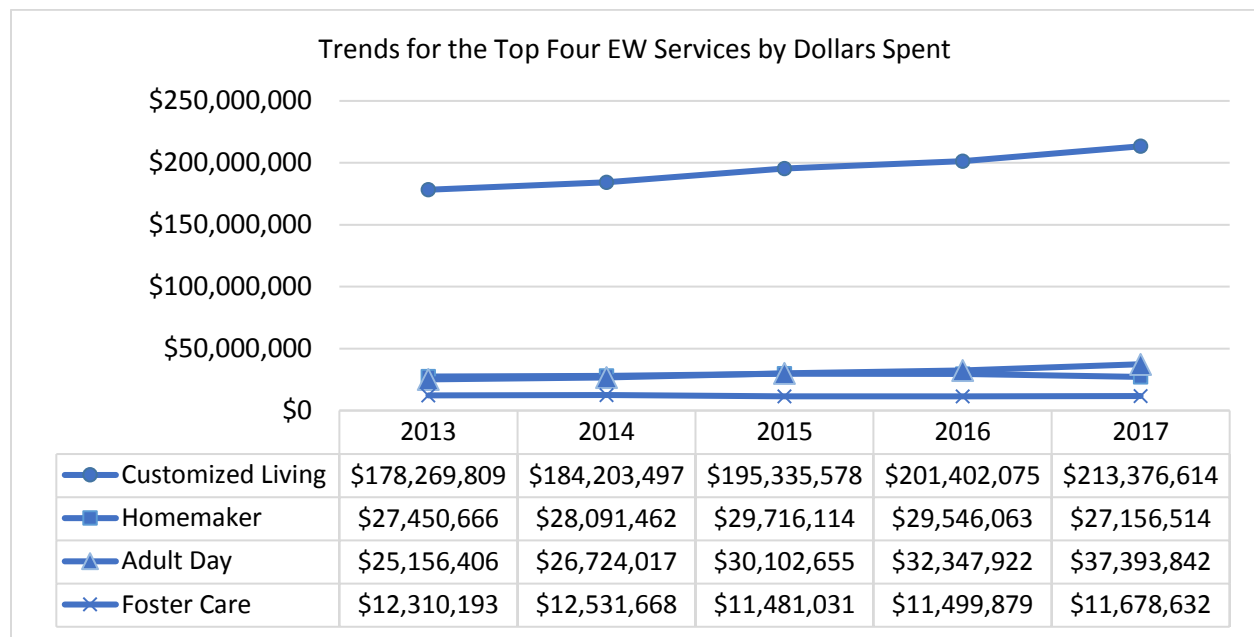


Source: Elderly Waiver Payment Summary Reports, State Fiscal Years 2013-2017

As the graph above shows, utilization of customized living is not only growing, a larger number and percentage of EW participants receive this service. In fact, more EW participants receive customized living than any other service. In 2017, 42 percent of EW participants received this service.

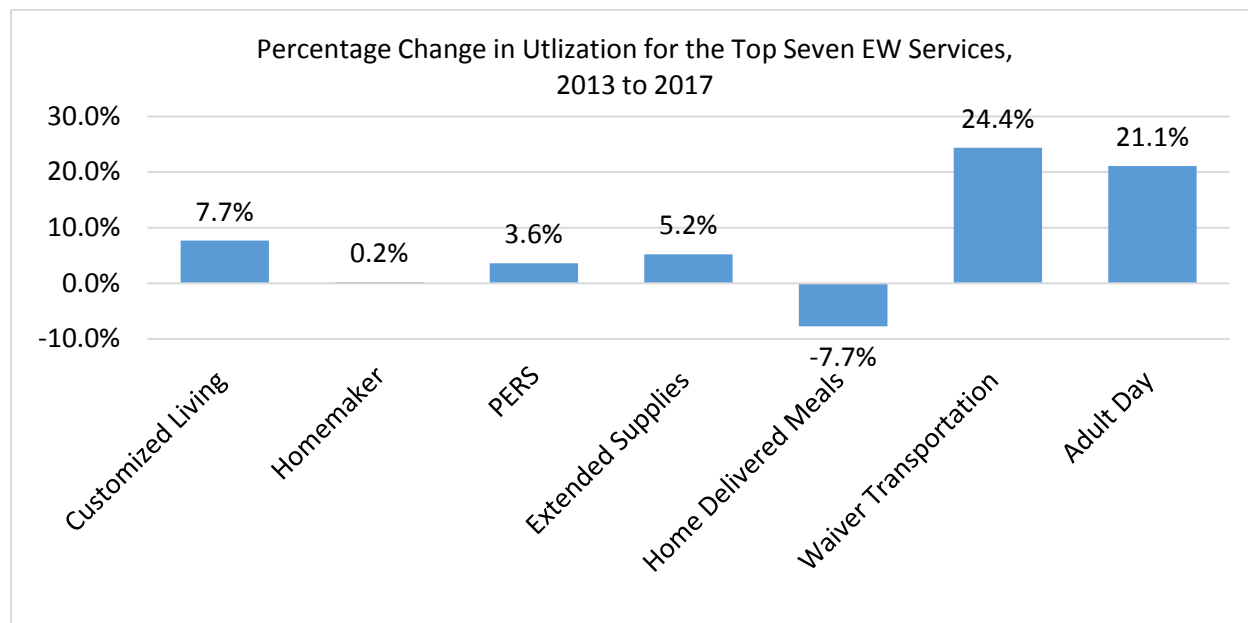
More dollars are spent on customized living than any other service as well, and spending for that service is increasing year by year. In 2017, more than \$213 million was spent on customized living, which represents 62 percent of total EW program spending for that year. Between 2016 and 2017, spending for customized living services increased nearly 6 percent. Year by year, spending on customized living services is growing between 3 and 6 percent.

While spending for customized living services is the most significant factor in the growth in overall program spending, spending is increasing for other waiver services as well. After customized living, the three top waiver services in terms of dollars spent are adult day services, homemaking, and adult foster care. Of these four services, however, spending is only increasing for adult day and case management. The graph below shows spending trends for these four services.



Source: Elderly Waiver Payment Summary Reports, State Fiscal Years 2013-2017

The graph below shows the percentage change in utilization for several services that have been heavily utilized historically. In addition to customized living, transportation, and adult day, which were discussed above, the utilization of homemaking, personal emergency response systems (or PERS), and supplies are increasing, but more modestly. Use of home delivered meals decreased between 2013 and 2017.



Source: Elderly Waiver Payment Summary Reports, State Fiscal Years 2013-2017

Meeting the needs of older Minnesotans while managing growth

The EW program has been extremely effective in meeting the needs of participants, in order to support them to remain living in their homes and communities, engage with their communities, and have the highest possible quality of life. At the same time, demand for these services continues to grow as our population ages and as more people choose HCBS over nursing facility services. Minnesota has implemented several strategies to meet the need for LTSS among older Minnesotans, as well many innovate and creative strategies to effectively manage growth in the EW program.

Reaching people early

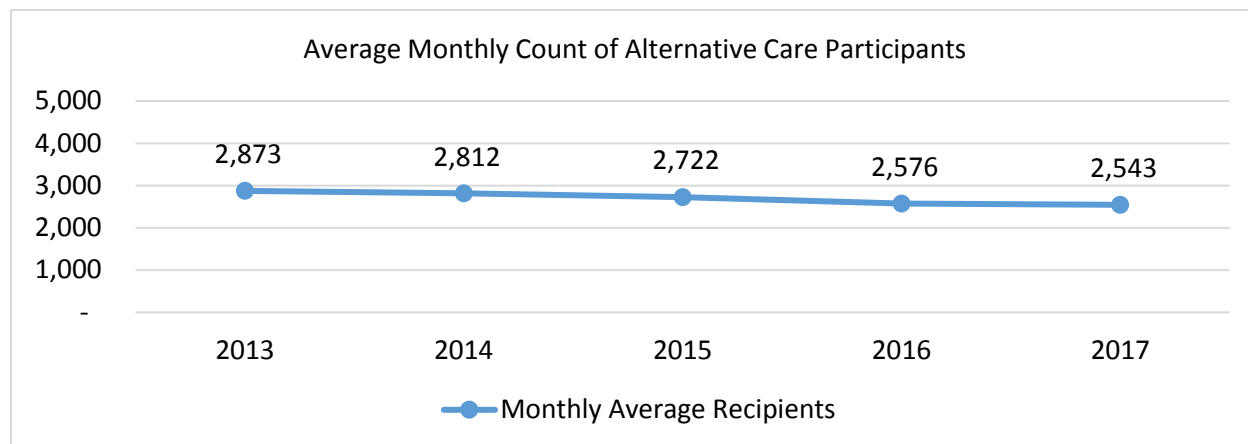
An important part of Minnesota's strategy to meet the needs of older Minnesotans as well as manage the growth in EW is to reach people before they even become eligible for EW. By reaching people early, when their needs are relatively modest, we can provide less-expensive services, prevent or delay their spenddown to MA, and prevent or delay the use of more expensive services such as nursing home or assisted living services. Minnesota has multiple strategies in place to reach people early.

Alternative Care

The Alternative Care (AC) program has been available in Minnesota since the early 1980's. AC provides HCBS to older adults who have modest income and assets but are not yet eligible for MA. AC serves people who are 65 or older, who need the level of care provided in a nursing home, but who choose to receive services in the community. In order to qualify financially for AC, a person must not have enough income and assets to pay for 135 days of nursing facility services. AC provides most of the services that are available on the EW service menu. The primary difference is that AC does *not* pay for residential services, such as assisted living or foster care.

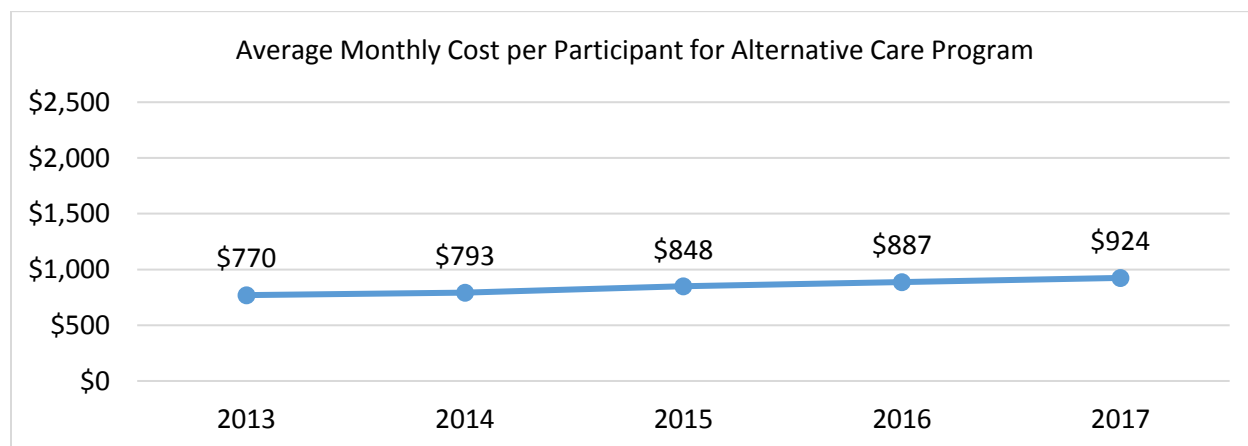
Through the AC program, Minnesota is able to serve older adults before they spend their resources and become eligible for MA. The program connects older adults with cost-effective community services that allow them to remain living in their own homes. The program helps participants avoid or delay nursing facilities and/or spending down to MA eligibility. The program also encourages the continued use of these cost-effective, non-residential services after a person becomes eligible for MA and EW.

Enrollment in AC has declined over the past five years; however, the decline in participation lessened between 2016 and 2017.



Source: Alternative Care Program Forecast, February 2018. Graph revised February 2019.

While enrollment has been declining, the average monthly cost per participant has been growing steadily in the last five years.



Source: Alternative Care Program Forecast, February 2018. Graph revised February 2019.

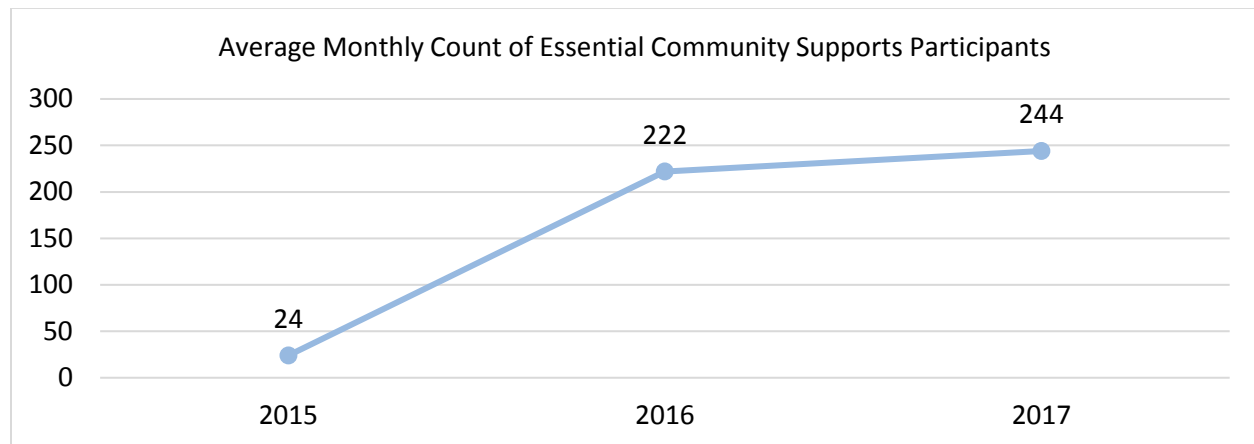
Essential Community Supports

The Essential Community Supports (ECS) program is a new program, implemented in 2015, that serves people with modest needs who want to remain living in their community. ECS provides HCBS to people who are 65 or older, who are *not* eligible for MA, who do *not* need the level of care provided in the nursing home, and who need some support to remain living in the community. ECS participants must meet the same financial eligibility criteria as AC participants.

ECS provides a limited benefit set: chore services, homemaking, personal emergency response systems (PERS), support for caregivers, help with household management, adult day service, home-delivered meals, and case management. The amount available to pay for services is very modest, at a little over \$400 per month.

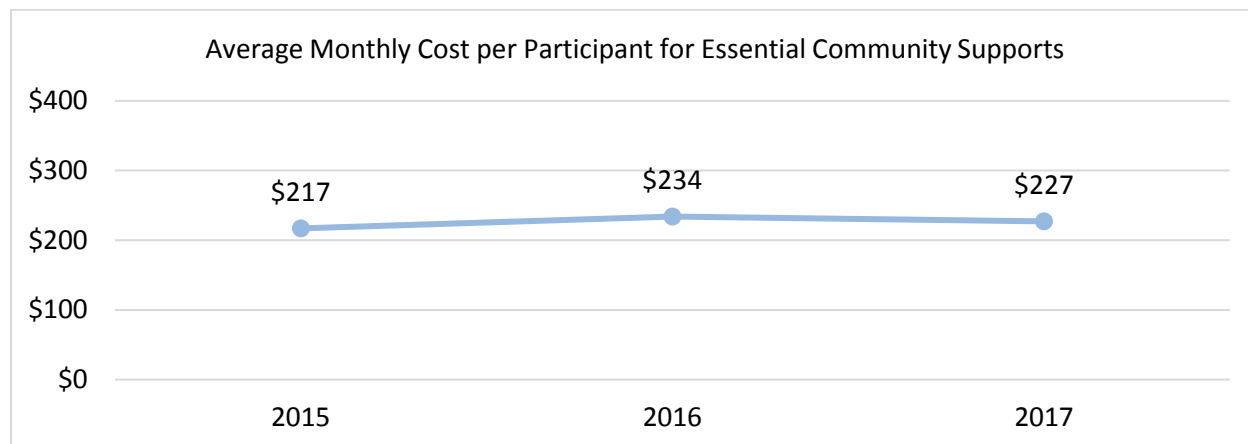
ECS was developed in response to changes in the state's nursing facility level of care (NF LOC), which governs eligibility for EW and AC, as well as MA payment of nursing facility services. People who do not meet the NF LOC criteria can be served with ECS program, which allows Minnesota to reach people before their needs increase, helping them to remain in their own home for a longer period of time.

ECS served a small number of participants in its first three years, and numbers were lower in 2015 as the program was getting started.



Source: Essential Community Supports Program Forecast, February 2018. Graph revised February 2019.

The average monthly cost for each participant remained fairly consistent in the program's first three years. The cost per participant is considerably lower than AC and EW due to the smaller menu of services and the lower monthly spending limits.



Source: Essential Community Supports Program Forecast, February 2018. Graph revised February 2019

Return to Community Initiative

The Return to Community Initiative (RTCI), implemented in 2010, is a state-wide initiative to assist private paying nursing home residents to return to the community early in their stays, e.g., 60-90 days after admission. The goals of the RTCI are to facilitate consumer choice in care setting and to achieve cost savings for the consumer and the Medicaid program. The RTCI is administered by the Minnesota Board on Aging (MBA) and it operates within the framework of the Older Americans Act and Area Agencies on Aging (AAA). The RTCI's focus on privately paying nursing home residents is unique nationally; most states have not delved into transitions for the privately paying NH residents. By supporting private pay residents who would otherwise remain in the nursing home to return to the community, the program helps extend person's private resources, therefore preventing or delaying the person's spenddown to Medical Assistance and achieving cost savings for the state.

A subset of non-Medicaid residents is targeted for the RTCI intervention using a profile score based on their desire to return to the community, health and functional status, and length of stay in the nursing home. Community Living Specialists provide individual support, including in-person visits, to residents who have consented to receive the support. Since April 2010, Community Living Specialists have assisted with over 5,800 discharges from Minnesota nursing homes.

Long Term Care Options Counseling

In 2011, the Minnesota Legislature passed a law that required all prospective residents, with the exception of individuals seeking a lease-only arrangement with a subsidized housing provider, to be offered long-term care options counseling and verification of consultation, prior to executing a lease or contract with any registered Housing with Services provider. (Housing with Services is the type of setting where assisted living services are delivered). This requirement is part of a strategy to ensure that people have information about a full range of options before making a decision to move to assisted living. If a person's needs can be met in their own home, the person's private resources will be extended, therefore preventing or delaying the person's spenddown to Medical Assistance.

Senior LinkAge Line® options counselors assist consumers calling for this service by doing the following:

- Review the consumer's current situation based on their values and preferences

- Connect consumers to services that are available and can meet the consumers' needs
- Compare financing options that may be available to help pay for their long-term care services
- Provide a verification number to be provided to the Registered Housing with Services setting
- Follow-up with the consumer to ensure their needs have been met

Supporting caregivers

Family and friends provide the majority of help needed by older adults to remain at home. In Minnesota, this unpaid help is valued at \$7.9 billion a year.⁴ Those family and friend caregivers continue to be involved when a person becomes eligible for EW. In 2017, 44 percent of EW participants received support from an informal caregiver to address one or more of their care needs. When an EW participant has the benefit of support from family and friends, the services provided through EW supplement what the caregivers can provide, and allow them to provide care longer. According to the most recent NCI-AD survey results for MN, 23 percent of EW participants report receiving most of the help they need from a spouse, partner, or other family member (25% for AC). An additional 14 percent report paying a friend or family member to provide most of the help they need (12% for AC). This demonstrates that EW participant needs are being met by a variety of formal and informal supports. This varied and wider network of support is critical, because just 19 percent of EW participants reported being married, and 38 percent of EW participants were living alone (2017).

The EW program is designed to support the continuation of informal caregiving when possible. One strategy to achieve this is through services and supports specifically aimed at supporting informal caregivers. These services include respite, training and education, and caregiver coaching and counseling. Adult day services are also used by caregivers, allowing a caregiver to attend to other responsibilities during the day, such as employment, while continuing to provide support to an older adult. Of these services, the most frequently-used are adult day service and respite. In 2017, 4,561 EW participants received adult day services, which represents nearly 16 percent of all EW participants. Another 102 participants received formal respite services.

The Consumer Directed Community Support (CDCS) option under EW is another way the program can enhance the role of informal caregivers. Through CDCS, an EW participant can choose to use their EW budget to hire family and friends to provide support. This may allow a caregiver to forego other employment and provide more support to the older adult. Participants may also appreciate receiving support from a person of their choice, who they know and trust. The caregiving experience may also be more stable and enduring, because of the personal relationship between the older adult and caregiver. The wider home and community based services system benefits, too. Paying informal caregivers through CDCS augments the long term care workforce, which is experiencing a workforce shortage. In 2017, 395 EW participants elected to use the CDCS option, which represents just over 1 percent of all EW participants that year. Another 215 people participated in CDCS through the Alternative Care program. This represents 6 percent of the program population that year.

⁴ https://mn.gov/dhs/assets/Caregiving_tcm1053-315631.pdf

Services tailored to individual needs

Minnesota has implemented a number of strategies within the EW program, to serve people with the right amount of services, tailored to their needs. By not over-serving people with more services than they need, the state can effectively manage spending in the EW program.

Individual budgets and service limits

A long-standing feature of the EW program is individual budgets. EW participants are assigned an individual budget amount based on their case mix classification, or level of need. Higher-need people have higher budgets, and lower-need people have lower budgets. Participants can choose the services, and the amount of services, that best meet their needs while staying within their assigned budget.

In 2009, the state created a new case mix classification (Case Mix L) for very low-need individuals who otherwise would have met criteria for Case Mix A (the lowest-need classification at the time).⁵ Participants in the Case Mix L classification have a smaller budget than Case Mix A.

In addition to individual budgets, the EW program also has limits on the amount that can be spent for some services. For example, there are limits on the amounts that can be spent on customized living and 24-hour customized living, based on a person's case mix.

Case Mix Classification Summary

A—Low Activities of Daily Living (ADL)
 B—Low ADL + Behavior
 C—Low ADL + Special Nursing
 D—Medium ADL
 E—Medium ADL + Behavior
 F—Medium ADL + Special Nursing
 G—High ADL
 H—High ADL + Behavior
 I—Very High ADL + Eating
 J—High ADL, Severe Neurological Impairment/3+ Behavior
 K—High ADL + Special Nursing
 L—Very Low ADL/Age 65+
 V—Ventilator Dependent

Source: DHS-3428B-ENG

24-hour customized living eligibility

24-hour customized living is a service that provides all of the components of customized living. In addition, it offers 24-hour supervision. Therefore, it is a more expensive service than customized living. In 2009 the state implemented new eligibility criteria that a person must meet in order to access 24-hour customized living.⁶ These eligibility criteria are beyond what is required to enter the EW program. This allows the state to reserve the 24-hour customized living service for people with greater needs.

Individual community living support (ICLS)

In 2013, the legislature authorized a new service under EW and AC, called individual community living support (ICLS). The service was launched in 2017. The service was developed as an alternative to more expensive residential services. ICLS allows participants to access a wide range of services and support in their own home, under a single service, without needing to move to a new setting to access those supports or use multiple providers. The service was first available to participants on April 1, 2017. Between that date and May 31, 2018, 80 participants utilized the service, in eleven counties.

⁵ Laws of Minnesota, 2009, Chapter 79, Art.8, Sec. 45

⁶ Laws of Minnesota, 2009, Chapter 79, Art. 8, Sec. 46, 47 & 49.

Managing costs within customized living

As noted previously in this report, customized living is a highly-utilized and relatively expensive service within the EW program. Minnesota has taken significant steps to manage costs, ensure consistency, and enforce policies for the customized living service.

In 2010, Minnesota launched the EW customized living tool. The tool is completed by case managers for all EW participants who receive customized living services (including 24-hour customized living). With the launch of the tool, the state established standard service components and component rates for customized living services. For example, the state established a standard rate for every hour of assistance provided to participants, such as assistance with homemaking, or assistance with personal cares. Through the tool, the case manager develops an individualized service delivery plan for the person. The tool also generates an individual rate for the person, based on the amount of component services the provider will deliver.

There are a number of features within the tool that support effective management of customized living services:

- The person's assessed needs are recorded within the tool. The case manager can only add time for a provider to assist with a need if the person's assessment indicates that need. For example, the case manager can only add time for a provider to assist with bathing if the person's assessment shows they need help with bathing.
- For each need, the case manager must also indicate within the tool that the person's preference is to have the customized living provider meet that need, rather than have the need met another way. For example, if a person has a need for medication set-up, they may choose to have a family member set up medications, rather than the provider. In this situation, the case manager cannot add time for the provider to set up medications.
- The tool gives case managers feedback when they are planning above the average amount of time that other case managers are planning for people with similar needs. This functionality helps case managers know how their service authorizations compare to other authorizations across the state.

Minnesota has been very successful in managing costs, ensuring statewide consistency, and developing service plans that meet the individual needs of each participant.

Change in nursing facility level of care (NF LOC)

In 2009, the legislature approved changes to the state's nursing facility level of care (NF LOC).⁷ A person must meet the NF LOC in order to be eligible for payment for long-term care services under Medical Assistance (MA), including payment for nursing facility services and home and community-based service (HCBS) programs. The nursing facility level of care (NF LOC) initiative was intended to:

- Contribute to sustainability in MA-funded long-term care programs by providing lower cost alternatives to individuals with lower needs;
- Standardize NF LOC criteria used statewide for both HCBS and NF populations; and
- Create objective NF LOC criteria to support equity in access to HCBS and NF services.

⁷ Laws of Minnesota, 2009, Chapter 79, Art. 8 Sec. 1-5, 16, 32-37, 39-44, 48, 65-67.

While the revised criteria were adopted by the Legislature in 2009, Minnesota could not implement this change until January 1, 2014 for individuals age 21 and older, and until October 1, 2019 for individuals under the age of 21 due to federal requirements included under the Affordable Care Act enacted in March 2010. Implementation was further delayed until January 1, 2015 by executive order to allow additional time for systems changes needed to fully implement transition services intended to support potentially affected populations.

DHS issued a [legislative report](#) in February 2016, summarizing the impact of implementing this change. The report showed that the initial impact of the change was small. Approximately 1.2% of people age 21 and older who were reassessed during 2015 were no longer eligible for their HCBS program due to the change in NF LOC. The majority of people affected were age 65 and older.

Challenges

Despite the significant progress Minnesota has made to effectively serve older adults in their homes and communities, Minnesota faces challenges in maintaining and continuing that momentum.

Availability of in-home services

As noted previously in this report, a key strategy to meet the needs of older adults is through in-home services, rather than serving people through nursing homes or through residential services such as assisted living. In-home services are less expensive, both for individuals who are using their own resources to pay for services, and for the state when people are on public programs. The state's goal is to serve people in their own homes for as long as possible. However, there are gaps in the availability of these important services.

The Gaps Analysis study gathers local information about the capacity of Minnesota's publicly funded home and community-based services (HCBS) system and continuum of mental health (MH) services and supports to meet the needs of all persons who need services. The Gaps Analysis is conducted every other year. Findings are reported in a biannual legislative report, "Status of Long-Term Services and Supports."⁸ The 2017 report found that, as in previous years, the most frequently-cited service gaps for older adults were for in-home services, such as transportation, companion, homemaker, personal care assistance, and chore services.

Workforce shortage

The 2017 "Status of Long-Term Services and Supports" report, mentioned above, also noted the pervasive impact of the workforce shortage across all populations and services. The shortage of available workers to deliver services impacts the availability of home and community-based services across the state. DHS convened a Direct Care/Support Workforce Summit in July 2016, and has since compiled a Directory of Leaders to help connect people and organizations who want to work together on similar efforts to address the direct care/support workforce shortage with those willing to lead these efforts.⁹ The consumer-directed community supports (CDCS) option under EW and AC is a critical model to help address this workforce shortage. The CDCS option allows participants to hire people in their

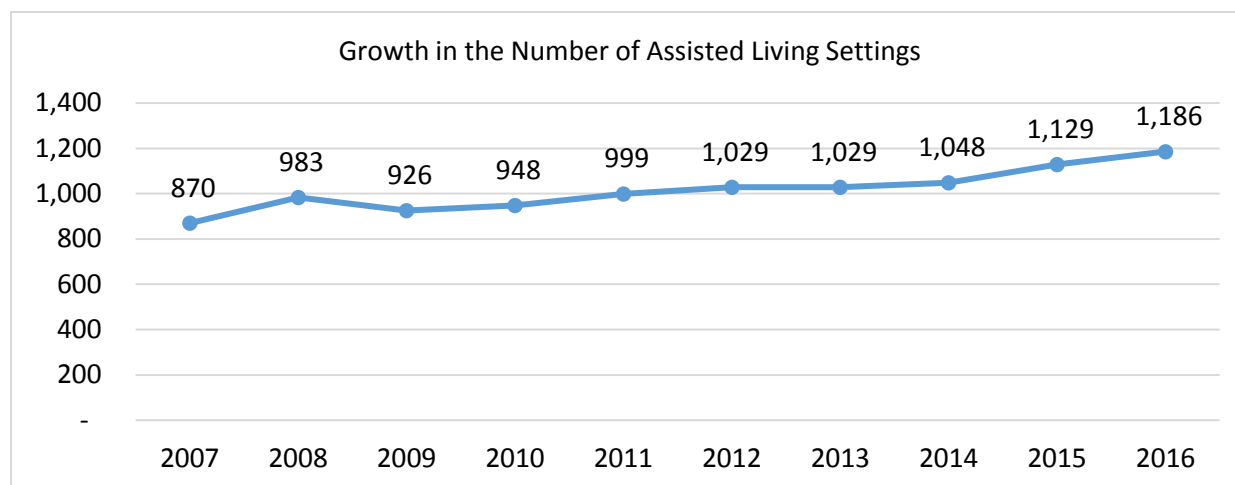
⁸ https://mn.gov/dhs/assets/2017-08-long-term-services-supports_tcm1053-309107.pdf

⁹ <https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/aging/direct-care/>

informal networks, such as family and friends, rather than rely upon a shrinking formal workforce to deliver services.

Growth in assisted living

Minnesota has seen significant growth in assisted living settings. Assisted living settings are a subset of housing with services (HWS) settings. These settings must register annually with the Department of Health. The chart below shows the growth in assisted living settings since 2007.



Source: Minnesota Department of Health

A significant number of EW participants who receive customized living services were living in an assisted living setting prior to becoming eligible for EW. In 2017, there were 1,089 EW participants who initiated customized living services and appeared to live in assisted living prior to services being initiated.¹⁰ In other words, participants spend their private assets on assisted living services until such point that they become eligible for EW and their services are paid through public resources.

The state lacks reliable data about the trajectory of private resource spend-down in these settings. For instance, the state does not have information about the average number of months a person pays privately for assisted living services before becoming eligible for EW. The state does have information about nursing home rates and length of stay in a nursing home, which has allowed the state to design strategies targeted at reducing nursing home stays. The state would benefit from this type of information related to assisted living, in order to inform strategic planning for future growth and expenditures within the EW program.

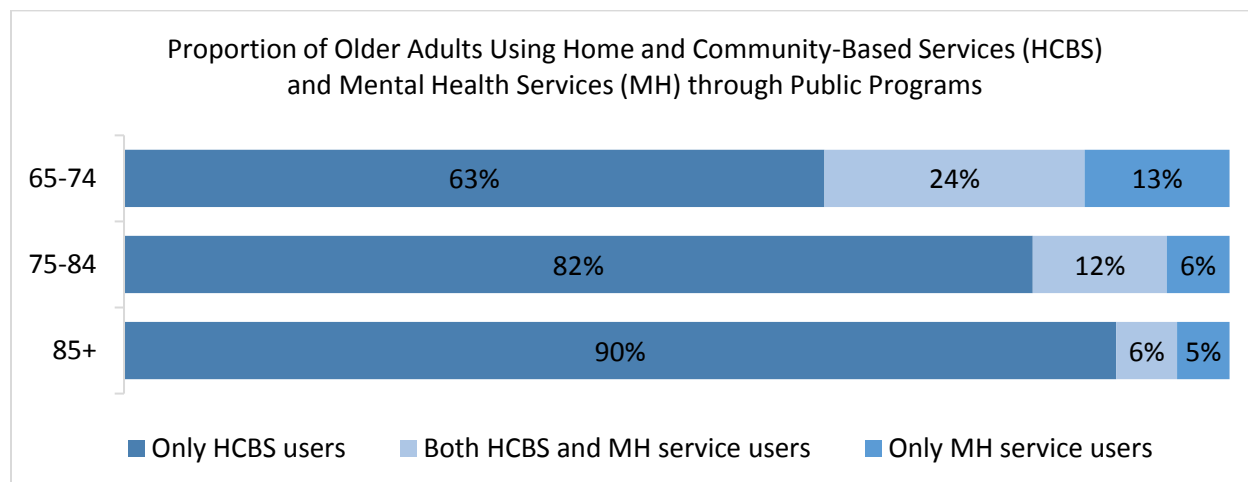
Serving people with complex needs

Older adults who seek long-term services and supports may have complex needs, meaning that their needs cannot be easily met with the traditional long-term service and support system. One example of

¹⁰ According to claims data for State Fiscal Year 2017, 1,089 unique participants had their first Long Term Care Consultation (LTCC) assessment, qualified for MA that month or 3 months prior, and had a Customized Living claim in the month of their LTCC assessment.

complexity is HCBS participants who also have mental health concerns. The chart below shows the proportion of older adults using HCBS and mental health services (MH) through public programs.

This may mean that participants have mental health needs, in addition to LTSS needs.



Source: Minnesota Department of Human Services MMIS, State Fiscal Year 2016

This may also mean that participants are experiencing homelessness, or are at risk of homelessness. Older adults are one of the fastest-growing groups of people experiencing homelessness. According to a study of homeless older adults conducted by Wilder Research, the number of homeless older adults age 55 and older increased 8 percent from 2012 to 2015. An increasing number of homeless older adults report one or more chronic health conditions. Health-related problems for homeless older adults are both more common and more complicated than for those of similar ages who have the advantage of permanent housing.¹¹

Chronic health conditions for homeless adults age 55 and older	2009	2012	2015
Older adults with a chronic physical health condition	66%	69%	71%
Older adults with a serious mental illness*	37%	41%	49%
Older adults with a substance abuse disorder	23%	24%	24%
Older adults with a serious or chronic disability^	87%	88%	89%
Older adults with a cognitive impairment	28%	35%	35%

*The diagnosis of "anxiety or panic disorder" was added in 2015.

^Serious or chronic disability includes mental illness, substance abuse disorder, or other conditions that limit work or activities of daily living.

Source: 2015 Minnesota Homeless Study, Wilder Research

In some cases, people with these complex needs are requesting long term services and supports for the first time when they are over the age of 65. The EW program must evolve as the older adult population

¹¹ <http://mnhomeless.org/minnesota-homeless-study/reports-and-fact-sheets/2015/2015-homeless-older-adults-6-17.pdf>

changes. The state must evaluate whether the long-term service and support needs of certain populations are different than the needs of people who have traditionally been served with the EW program. Then the state must make changes to better meet the needs of this population, by updating LTSS service and program design, and by improving coordination and integration with the systems that serve people with mental illness and people experiencing homelessness.

Where do we go from here?

Minnesota has a history of successes upon which to build. Minnesota's publicly-funded long-term services and supports for older adults can be not only maintained, but strengthened, in order to serve older adults now and into the future. We must take steps now to ensure this happens.

Ensure equity

Minnesota has built a strong program that provides high quality services to a broad population. But there are populations for which we need to improve. As noted earlier in this report, the EW population is becoming more diverse, as the state's overall older adult population becomes more diverse. Service systems have traditionally been developed with the majority white population in mind. The state must continue to evaluate the extent to which service systems and service design is meeting the needs of communities who experience inequities, including communities of color and American Indians. Considerations of equity must be embedded in all decisions regarding operations, programming, investments, and policy development.

Address service rates

In order to ensure that services are available for public program participants into the future, it's critical that Minnesota maintain service rates that are sufficient and reasonable. In 2017, the Minnesota Legislature authorized a new rate-setting methodology for a number of services covered under Elderly Waiver, Alternative Care, and Essential Community Supports:

- Adult day (EW, AC, ECS)
- Chore (EW, AC, ECS)
- Companion (EW, AC)
- Customized living (EW)
- Foster care (EW)
- Residential care (EW)
- Home delivered meals (EW, AC, ECS)
- Homemaker (EW, AC, ECS)
- Respite (EW, AC)
- Individual community living support (EW, AC)

The legislation provides specific direction and formulas for how rates should be calculated with the new methodology. Rates will be built by calculating a "base wage" for each rate, then applying certain factors.¹² The legislation states that the new methodology will be *partially implemented*. On January 1, 2019, the rates for affected services shall be the sum of:

¹² Minnesota Statutes, 256B.0915, Subd. 11-14

- 10% of the rates calculated with the new methodology
- 90% of the rates calculated using the methodology in effect as of June 30, 2017

Further implementation of the new methodology (i.e. 20% new methodology/80% previous methodology) will require legislative action.

The Legislature also directed DHS to conduct an evaluation of the new rate methodology, in consultation with stakeholders, to determine if the assumptions within the methodology are appropriate and reasonable.¹³ DHS must submit a report to the legislature by January 1, 2019 that includes any recommended changes to the rate methodology.

Through the evaluation, DHS will be able to determine not only the appropriateness of the rates established with the new methodology, but also the degree to which current rates support reasonable costs for providers to deliver services. DHS may recommend a faster implementation of new rates for services where the historic rates have been especially low compared to reasonable costs.

Develop and promote cost-effective services

The state must continue to promote and enhance cost-effective, in-home services that are tailored specifically to the needs and preferences of the person being served. The state must continually evaluate and address barriers to delivering those in-home services. The state must ensure that the regulatory and administrative requirements for those services is appropriate and manageable, in order to ensure providers' interest and ability to deliver those services. The state should also consider whether to develop new purchasing strategies that would support and expand in-home services, in order to address critical gaps in service availability.

The Consumer Directed Community Supports (CDCS) option provides the greatest degree of flexibility for the person to purchase the services the supports that meet their needs, while maximizing the use of informal supports. Unfortunately, some EW and AC participants determine that CDCS is not a viable option because the budget for services is less than what is available when they select traditional EW/AC services. The state should create parity between budgets available for CDCS participants and non-CDCS participants, in order to ensure that CDCS is a viable option for more people.

Evaluate incentives for Alternative Care

As described above, the Alternative Care (AC) program provides home and community-based services to older adults who have modest income and assets but are not yet eligible for MA. The program reached a peak annual enrollment of 12,193 in fiscal year 2002. The legislature approved changes to the program in order to address budget constraints.

- In 2005, the legislature removed residential services, such as assisted living, from the AC benefit set. Residential services are now only available through the EW program.
- In 2003, the legislature approved lien and estate recovery requirements for AC participants. The legislature repealed the lien requirements in 2005. The state continues to recover the cost of providing AC services to participants from their estates following their death.

¹³ Minnesota Statute, 256B.0915, Subd. 17

The above changes coincided with a sharp drop in AC enrollment. Currently, Minnesota serves approximately 3,600 participants per year. Enrollment in AC is relatively stable, despite the increased number of older adults in Minnesota. The state should evaluate whether eligibility, programmatic, or other changes to the AC program would incentivize more people to participate in the AC program, and whether that increased participation would result in cost savings to the state.

Understand the spenddown trajectory

People become eligible for the EW program after spending their private resources on LTSS. People choose to pay privately for both in-home services as well as assisted living services. This is known as “spending down” to MA eligibility. However, the state lacks meaningful data about this spenddown trajectory from private pay to public pay status. For example, how much money do people spend on services before applying for EW? How long do they pay privately for services? What services do they buy? What is the difference in spenddown trajectory for people who pay for in-home services vs. people who pay for assisted living? Answering these questions would help the state develop smarter, data-driven strategies to delay or prevent spending down to MA.

Pay for quality in assisted living

As noted throughout this report, the growth of assisted living is one of the most significant features of the LTSS landscape in Minnesota. The cost of assisted living (or customized living) drives a large share of the spending in the EW program. The state’s goal is to promote and ensure high-quality, cost-effective services that meet the needs of participants and allow participants to remain living in and connected to their communities. To that end, the state is exploring ways to promote quality services through value-based purchasing strategies for assisted living.

Minnesota is currently participating in CMS initiative, through the Medicaid Innovation Accelerator Program (IAP), that will support the state to develop this value-based purchasing strategy. The Medicaid IAP is offering a new technical support opportunity that is intended to build the knowledge base and capacity of states to adopt strategies that tie together quality, cost, and outcomes for community-based LTSS. Minnesota is seeking technical assistance specifically to design a value-based purchasing strategy for customized living services paid by Elderly Waiver, including for services provided to people with dementia. Through this 1-year technical assistance opportunity, Minnesota will develop a roadmap for design and implementation of this strategy.

Conclusion

Minnesota can be proud of its EW program. The program is undeniably achieving the state’s goal to serve MA-eligible older adults in their homes and communities, rather than in institutions. Participants report high levels of satisfaction with the program, and that the program is meeting their needs. The state is now faced with a new demographic reality and must respond. The state can build on a strong foundation to ensure this program continues to meet the needs of older adults for many years to come.